Overview & Scrutiny

“Making the LINks”

Public and Patient Involvement in Brent

First report of the Local Involvement Networks (LINks) Task Group

March 2007

Chair's Foreword

This has been a very short, but interesting piece of work. We, as a task group, have been hampered by the long legislative delay that has emerged in bringing the LINks proposals to fruition. However, we have used this opportunity to have a good look at the issues involved and the nature of public and patient involvement in our Borough. In our recommendations we have tried to focus on practical measures that we can take now to help facilitate development in the future.

At a time of great change within the NHS as a whole, and a very public debate concerning resources, the needs and views of the patient become all the more important.

The LINks proposals are not perfect, but they do provide us with an opportunity to improve how we gather local intelligence and pick up concerns from those who have experience of services first hand. We have more to do in exploring the effectiveness of the local patient groups and the avenues in which scrutiny can more effectively identify issues of common cause.

It will be necessary, therefore, for the Health Select Committee to revisit this issue, once the Local Government and Public Involvement in Health Bill becomes an act of parliament.

We hope that this report will allow for closer working between the Health Select Committee, the Local Strategic Partnership, and the local Patient Forums.

I would like to thank those representatives from each of the local NHS trust PPIFs who gave up their time to help us get a handle on these issues, in particular Mansukh Raichuria for his contribution.

Cllr John Detre
Chair
LINks Task Group

Introduction
The Health Select Committee established a time limited task group to examine the Department of Health's proposals to reform Patient and Public Involvement Forums (PPIF) and introduce Local Involvement Networks (LINks). The focus of the task group investigation was new governance arrangements, in particular how the proposed LINks could fit with existing bodies such as the Council's Overview & Scrutiny structure and the Health & Social Care Partnership Board (HSCPB) of the Local Strategic Partnership (LSP).

As the introduction of LINks is dependent on forthcoming legislation and parliamentary time, the task group agreed that it's work would act as a useful vehicle with which to establish closer links between patient groups and the Council's scrutiny function, as well as understand the concerns of those forums through a period of potential transition.

Membership
The following members served on the task group:

- **Cllr John Detre**
- **Cllr Ralph Fox**
- **Cllr Daniel Bessong**

- **Mansukh Raichuria (Chair, Brent tPCT PPIF)** was co-opted to provide a perspective from the Forum.

Themes
The work of the task Group adopted the following themes for discussion:

- The role of the Council's Health Select Committee (Overview & Scrutiny).
- Links to the Local Strategic Partnership.
- The practicalities of establishing LINks - Funding and Support.
- Current arrangements for Public and Patient Involvement- response from PPIF.

The task group met three times during January and February 2007.

Officer Support
The task group received officer support from:

- **James Sandy**, Policy & Performance Officer

- **Mike Bibby**, Strategy Planning & Performance Manger, Housing & Community Care.

- **Owen Thomson,** Head of Consultation

Context

> "*If we are to create a truly patient-led service, centred around the needs of both individuals and communities, it is essential that we create a stronger voice for patients, service users and citizens at all levels of the health and social care system*[1]".
>
> **Rosie Winterton,**
> **Minister of State for Health Services**

Proposals to create **Local Involvement Networks (LINks)** form part of the Government's wider "Our Health, Our Care, Our Say[2]" agenda, which aims to increase and improve public and patient involvement, and to allow more people to have a greater say in the services they use locally. The vision is to develop patients as "active partners" in healthcare and to challenge passivity in relation to service delivery. Tapping into the experiences and knowledge of local patients and patients groups allows for better, more efficient, service planning that is more in tune with the needs of the local community.

Furthermore, the proposals for LINks seek to address the need to broaden the basis on which patient groups influence and inform, reaching out to those who do not normally get involved or find it difficult to do so. They should operate in an inclusive way with a membership that includes user groups, local voluntary and community sector organisations. The LINks approach is also an attempt to ensure that such groups can effectively react to changes in the health and social care sector and be supported effectively in influencing them further.

LINks will primarily:

- Provide a flexible way for local people and communities to engage with health and social care organisations.
- Support and strengthen open and transparent communication between people, commissioners and providers.
- Make sure organisations that commission and provide health and social care services are more accountable to the public and build positive relationships with them.
- Gather information from a wide range of people and a wide range of sources – information about what local people need in terms of both their health and social care services and about their experiences of using these services in their area.
- Analyse information and decide what to pass on, making recommendations to organisations (commissioners, providers, managers, OSCs and regulators) responsible for delivering and scrutinising health and social care services.

(Source: Department of Health)

[1] "A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services",P3, Department of Health, July 2006.
[2] "Our health, our care, our say: a new direction for community services", department of Health, January 2006.

A LINk then will be a local "umbrella" organisation, constituting community and patient groups, as well as interested individuals. It will have a flexible and crosscutting membership, dependent on the issue concerned. Importantly, it will be established on an area, rather than a NHS Trust, basis. The LINk would be supported and developed by an organisation, through a "host authority".

Consulting on its new proposals[3] the Department of Health sought comment on five main elements:

- Creating Local Involvement Networks
- Overview & Scrutiny committees
- Duties of providers/ commissioners to involve and consult
- A stronger national voice
- A stronger voice in regulation

Such changes will have an impact on existing frameworks for involvement and their relationship with other public bodies (such as the Council and LSP).

In September 2006 Brent Council and Brent tPCT produced a joint response[4] to the LINks proposals, which highlighted the following issues:

- The need for effective public engagement in moving towards the new arrangements and a clear process outlining the expectations of key partners.
- Capacity amongst the community and voluntary sector to provide support to LINks via the host authority.
- The need for a ring fencing of funds to local authorities to create LINks.
- The need to ensure that the existing groups and local expertise is not lost and those groups are not weakened by the proposals.
- Improve co-ordination and partnership of local groups, to help promote common priorities.

In its response to the consultation the Government acknowledged a number of concerns around the tendering arrangements likely for LINks, the need for a clearer definition of roles, and issues concerning inclusion and the recruitment of members. Significantly, the response confirmed that the LINks would assume the right of inspection and right of entry currently invested with PPIFs. LINks then will be given the powers of their predecessors to enter and observe services to validate their evidence and back up any concerns raised[5].

The Local Government and Public Involvement in Health Bill was introduced on the 12th December 2006, serving as founding legislation for the Government's white paper on local government "Strong and prosperous

[3] Through its document for information and comment, July 2006.
[4] A copy of the Joint Response constitutes **Appendix A** of this report.
[5] "Government Response to a stronger local voice", Department of Health, December 2006,2.13,P28

communities[6]" and the LINks proposals contained within "A stronger local voice". The Bill formalises the themes and practical arrangements outlined by the Government. It is anticipated that the Bill will receive assent towards the end of this year. This legislative gap, therefore, led the task group to focus more on principles and to make recommendations that will assist the development and transition of arrangements for public and patient involvement locally.

Task Group Themes

(1) Overview & Scrutiny

The Health Select Committee has delegated authority from the Council's main Overview & Scrutiny Committee (OSC) to scrutinise and develop policy with regards to public health and "well-being" in Brent. It plays a key role in checking the performance of local NHS trusts and organisations that work in partnership with the council, or that provide services within the borough. It also acts on behalf of the community to investigate plans and consultations that have implications for the future design and delivery of healthcare in Brent.

The Council's overview and scrutiny structure was reviewed in 2006 with new arrangements taking effect from September 2006[7]. The former Health Overview Panel (the predecessor to the Health Select Committee) identified patient involvement as an area in which it would like to make more progress, following a review of Brent's health scrutiny arrangements conducted with support from the Centre for Pubic Scrutiny (CfPS)[8].

Members considered that the most important first step in relation the Committee was formalising the link it has with existing forums and patient groups. This would allow for a regular information exchange, provide access to local intelligence, and also help to identify possible topics for scrutiny. It was therefore agreed that referral from patient forums should be a standing item for each meeting of the Health Select Committee. This would serve as a time-limited item that could provide updates and flag up issues of concern. In addition, it would establish a process by which the annual or quarterly plans envisaged in the LINks proposals could be considered. Focused items could highlight both positive and negative aspects of services from a "frontline" perspective.

The task group also felt it important that as elements of the LINks proposals involve scrutiny committees focusing more on those bodies commissioning services, and with the LINks focused more on those who receive such services, continuity would be important with regard to respective workloads. An observer from the patient forums could then be appointed to help facilitate closer working on issues of common interest. As the LINk will be area based, one observer could serve on behalf of the four trusts. As the task group does not wish to be prescriptive, it would be up to forums to reach agreement as to

[6] "Strong and prosperous communities: The Local Government White Paper", Department for Communities and Local Government, October 2006.
[7] Brent Overview & Scrutiny Structure **(Appendix B)**
[8] Health Overview and Scrutiny: Background Paper, Policy & Regeneration Unit, June 2006

how this is arranged (for example it could be by rotation). This would firm up necessary channels of communication in the run up to the establishment of the LINk.

The task group note that formal powers of referral and inspection look likely to be given to LINks under statue. The recommendations made here are designed to compliment, rather than complicate, or frustrate these.

(2) Local Strategic Partnership.
The Local Strategic Partnership is an inter-agency forum for public, private, voluntary and community sector organisations within the Borough.

Within Brent's LSP exist a number of individual partnerships that focus strategically on specific sectors. These sectors are divided into sub-groups according to the relevance of the provider. The Health and Social Care Partnership Board takes a lead role in developing the strategic direction of health and social care services and health-improving initiatives across the Borough, taking into account local needs, national direction and priorities.

The proposed remit of LINks would provide for a critical commentary on the commissioning of health and social care services locally. It could develop a duel role in both scrutinising activity and providing an informed provider perspective.

The task group discovered that there could potentially be a number of multi-membership issues once LINks are established, as many individuals are involved with a host of forums and groups. In the face of this involvement of the same personnel at a number of levels, it is even more important to clearly define roles and responsibilities within the LINks framework.

The complexity of the LSP structure, the Council's decision-making structure, and the organisation of NHS trusts present challenges to public understanding and engagement. A streamlining of processes would be useful upon creation of any new bodies. **Appendices (C)** and **(D)** of this report map out the current arrangements[9].

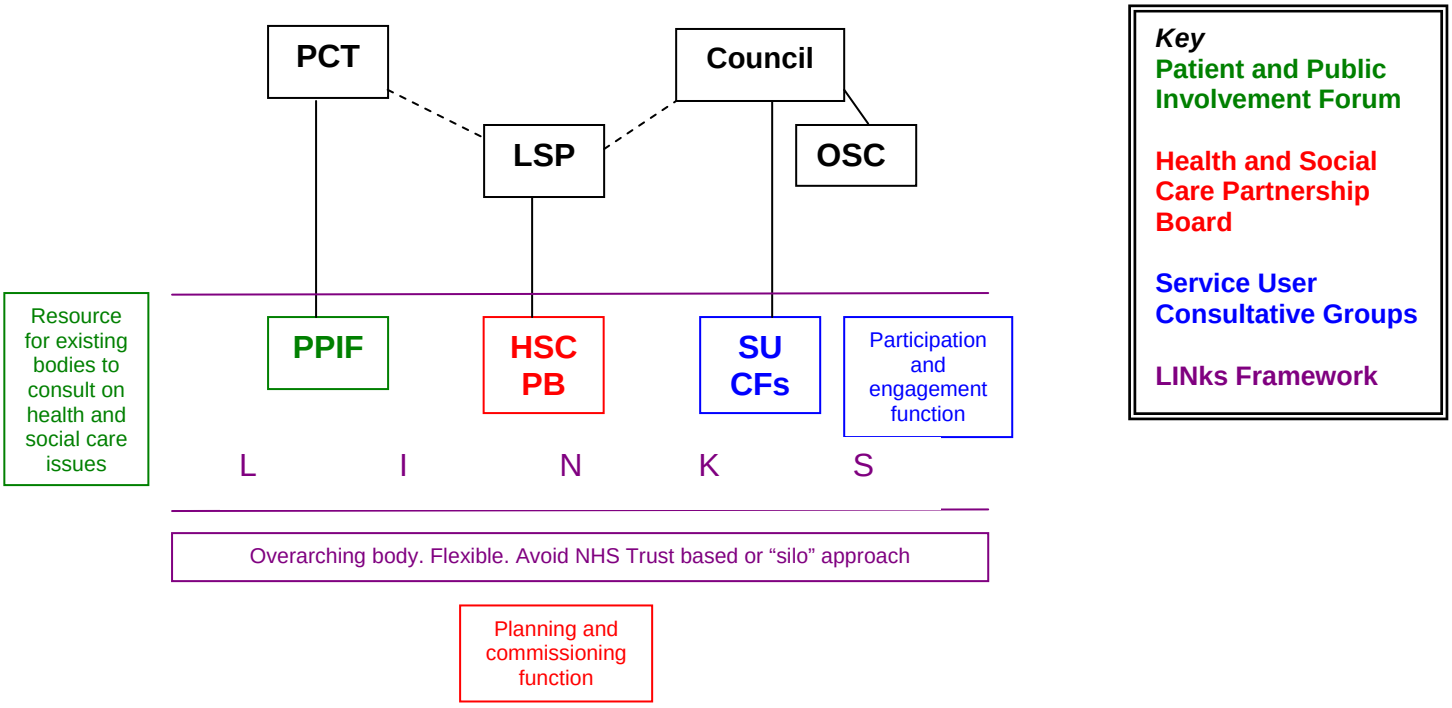
LINks should be empowered with a formal and direct reporting line to the LSP, allowing them to make recommendations. A LINk is a scrutinising body and not primarily a consultative one. It will be given powers to investigate and request, gather evidence and advise. Any framework should ensure that the LINk is able to provide an effective challenge.

The task group noted that there could be a potential conflict of interest for organisations that are members of the LINks as they could also be involved directly in service provision or commissioning. More guidance from the Department of Health is needed to avoid the potentially negative consequences of this.

[9] Appendix (C) "Local Strategic Partnership Structure" and Appendix (D) "health & Social Care Services in Brent Partnership Arrangements"

Task group members proposed a simplified model through which the LSP and OSC strucutures could relate to LINks.

Possible "LINks" Model



"Early Adopters"

The task group sought to gather more information about the development of LINks at the local level by contacting those Council's identified as "early adopters" in the Minister's letter to Local Authority Chief Executives[10].

Durham County Council

Durham actively lobbied to secure the early adopter status, which the Council sees as a useful vehicle to shape the future involvement process. Existing bodies and partners have been included in the development to help shape the county view and share wider experience. Current thinking around LINks is that it could be based on a number of themes, such as:

- Geographic partnership
- Area basis within County
- Health inequalities
- Vulnerable communities

[10] Letter to all Local Authority Chief Executives with social services responsibilities from The Rt.Hon Rosie Winterton MP, Department of Health, 9th November 2006.

Durham have established a project team of around 20 people, comprising key players from the voluntary sector, partners, patient forums.
Centre for Patient and Public Involvement in Health (CPPIH) have provided a time-limited "transition co-ordinator" to support this work. Workshop discussions are planned to feed into a stakeholder's event.

Doncaster Metropolitan Borough Council
LINks work is being led by the Council's policy team, who have identified a working group, which will be supported, by CPPIH. Working group has yet to meet and no details of funding from the Department of Health have been given to date. An event is planned in March to focus on LINks.

Hertfordshire County Council
They have been asked to identify best practice within their own area. CPPIH support has been provided in terms of staffing and facilitation. Possibly chosen as an early adopter because of the significant urban/rural split of the County. Good track record on consultation and hoping to use existing community groups. Hertfordshire want to try and structure the LINks to stop any one group becoming the dominant voice.

Kensington & Chelsea
The Early Adopter Project Group for K&C involves local agencies (the PCT, all the local PPIFs, Council officers, local BME Health Forum, CPPI people).

So far its has discussed the latest developments on LINks –

- The Governments response to its consultation on "A Stronger Voice"
- The points raised by MPs in the recent debate on the Local Govt & PPIH Bill
- The likely timeline for the Select Committee report on PPI (late Spring).

The group has also discussed the membership and terms of reference of the Project Group: who should be involved and what it should do. Membership is wide-ranging and will look at how to identify and bring key local stakeholders together to consult on what the local LINk might look like.

Any models that emerge will then go back to the DoH for consideration. The CPPIH itself will be phased out towards the end of the year.

Kensington & Chelsea will be responsible for procuring the LINK by inviting local organisations to host it (through competitive tendering), the guidelines for which are currently being developed. Procurement will be at arms length from Social Services commissioning since part of the LINk's brief is to comment on Social Services as well as Health. Money will come through the LAA and the LSP. It looks as though there will be an average of £180K available per LINk, though it is also clear that some areas will get much more and some will get much less depending on defined need. LINks will be part of a complicated structure of public involvement in health & local govt provision, with the purported ability to influence Local Area Agreements. They will have the power to refer matters to Health and social care OSCs.

Two workshops are planned to look at the relationship with Scrutiny and the relationship with the K&C Partnership. There are plans for the Project Group to meet every month and produce a rolling project plan.

K&C have conducted some work on identifying opportunities and challenges for LINks which has revealed that local agencies in the project group can work much more closely together in the run up to LINks. For instance, if the BME Forum has an issue they could raise with the PCT through the OSC. The PPIFs will now look to work more closely with the OSC.

The project group has then become a catalyst for people to think about working together now rather than waiting for structures to change.

Of the Councils contacted, most stated that they expected more support and more speed from the Department of Health. There is an unclear picture as to why these sites were chosen and what criteria for selection applied at the national level. Clearly factors such as size and deprivation of the borough, as well as geographical characteristics and Council structure were considered.

The Department of Health have provided support through a dedicated project manager in each pilot area via CPPIH with a focus on community development and the potential scope of LINks. The department are currently drafting "key documents" and "model specification" contracts and have indicated that these could be shared with interested authorities outside those nominated as early adopters.

(3) Establishing LINks

The task group were keen to explore the practical factors necessary for establishing LINks once the legislation is in place, primarily this involved funding and support.

The Department of Health have said that:

"*Each local authority with social service responsibilities will be appropriately funded to carryout a new statutory duty to make arrangements providing for the establishment of a LINk in its area*[11]".

furthermore:

"*Funding for LINks will be provided from central government to all relevant authorities, which will, perhaps jointly where that seems appropriate, contract with local organisations such as voluntary and community groups or social enterprises to identify the most appropriate arrangements for hosting and providing support to the LINks. Given the skill requirements of support organisations, it is likely that they will chiefly be drawn from local non-profit organisations with skills in community development and networking*[12]".

[11] A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services", Department of Health, July 2006.

[12] Letter to all Local Authority Chief Executives with social services responsibilities from The Rt.Hon Rosie Winterton MP, Department of Health, 9th November 2006

The task group asserted that the amount of money available will be a sticking point as it will determine the effectiveness of the support provided and the capacity of the LINk as a whole. Currently PPIFs are funded around £33,000 per annum (this is per trust forum). In addition, the amount allocated to LINks will have a bearing on the standing orders that are employed and the duration of any contract that the Council draws up as the "host".

The size of the organisation adopted as a LINk provider will also determine the both the costs it incurs and the shape of the network. Larger organisations may provide a consortium of support, but there is a concern that the economy of scale undermines the localised nature of the proposals.

The Minister has been very clear that an officer within the Council, who will be responsible for tendering the LINks provider, as well as its auditing and monitoring, should not be drawn from the social care side of the Council. The task group also agreed that this role should be kept distinct from scrutiny (Policy).

Owen Thomson, Head of Consultation, has been named as the officer who will facilitate the LINks process, with support from the procurement team. This process itself will be determined by the contractual model which is forwarded within the legislation. It will need to embody a proactive tendering process for the administrative body and those representative groups involved.

It was noted that the procurement process is based on several "unknowns" and that local variations of LINks should be encouraged within central guidance. The need to understand local needs will be essential in developing an effective service

Members were keen to use existing forums to involve groups in the development and creation of LINks and ensure that existing forums were informed of its work.

(4) Local Public and Patient Involvement Forums
In order to get a truer picture of the activities, capacity, and concerns of the local PPIFs, members invited each to provide a response to the task group's themes of investigation and comment on the LINks proposals in general.

North West London Hospitals Trust PPI Forum
"The forum has an established membership; many of whom have witnessed previous reforms and changes from Community Health Councils to PPIF. Information received has been vague and unspecific. Among the forum's main concerns is that the status as an apolitical body with an independent agenda could be threatened by the future "hosting" arrangements.

The lack of "ring fenced" funding also raises questions about capacity in the long term.
The current system is not perfect, but does allow forums to network nationally, and provides targeted training. There has been no explanation as to why the forums have to be abolished rather than reformed. There is a fear that the forum could loose those members, and therefore knowledge and experience, it has built up over the past few years. The introduction of LINks will be expensive.

We have fought to be taken seriously by the Trust and we now have a very good relationship and are working well together. Several of our members find it difficult to commit to regular attendance. The idea that a LINk would allow membership to be fluid and people could "drop in and out" could lead to discontinuity and adversely effect monitoring schedules and other planned activities. People will need to commit to membership as it is necessary for them to have an understanding of the Trust , who the main personnel are, and how we work in relation to them. Without this we will be less effective.

PPIFs have developed a number of advantages, which include our "critical friend" role, training from CCPIH, statutory rights of inspection, CRB status, and the ability to take on practical activities such as cleaning inspections.

LINks threatens us with the loss of our relationship with the Trust and the focus of our work will suffer. Lumping us together geographically will dilute expertise in acute, primary, mental health, and ambulance services even if we can form sub-groups.

Both of the main hospitals in the Trust are based in Brent, but serve a majority of Harrow residents. This provides difficult for the area-based scenario presented in the proposals".

London Ambulance (LAS) Patients Forum
"The abolition proposal contained in the recent 'Local Government and Public Involvement in Health Bill' will set-back patient and public involvement in the NHS and hamper efforts to improve patients' service. Forum Members are doing a great job, have strong links with communities and patients across London and have developed strong and effective links with the LAS. The Government's abolition plans would destroy the Forum and set back patient and public involvement. Our Members are committed to working with patients and the public to improve NHS services and have no time for the Department of Health's repeated reorganisations. Our Members have decided to resist the Secretary of State's abolition plan and continue their work to improve ambulance services and to represent London's patients and the general public in the NHS".

From LAS PPIF Press Release: Patients Forum Says 'No Minister'! Tuesday January 9th 2006.

Central and North West London Mental Health NHS Trust PPIF

"The effectiveness of the forum has relied on full time support staff, a well-connected chair and deputy, as well as a strong member structure. The forum needs to be properly resourced and supported to remain effective. It needs support that has health knowledge, rather than just administrative competence.
The forum is still not recognised on the Department of Health's list of consultees, as we are not a statutory body despite our powers of inspection. We have had limited support from CCPIH and have no budget, our expenses are covered and our support is paid for. However, we do not manage our support staff, which can present problems in prioritising work.
Membership is a difficult issue for mental health. We have 6-8 members of the forum and recruitment problems, mainly that people have other commitments, sit on other bodies, and have caring responsibilities.
Our concern with LINks is that there is no grass roots structure and has been no national debate on the forums.
The trust has 100 locations across central and northwest London, it has taken us a while to find the centres of power and get to grips with the organisation. An area-based approach is impracticable in this context. The trust provides services in 4-5 boroughs. Mental health care implies multi-borough activity and LINks can't accommodate this.
The success of our informal visits and inspections has relied on good planning and support. It is often the case that people only come to the forum when they need it.
We are concerned that LINks could be hi-jacked by specialist services, rather than consider general patient concerns.
The Healthcare Commission Annual Health Check has made a fundamental difference, as it requires direct comment from the PPIFs and scrutiny, but feedback to groups is not in the process.
The focus of our work is on quality of service, user perspective, and the human element. The "host" arrangements that are proposed should make no difference, as long as they are properly managed and supported. We will need more training from the SHA to help us understand how things work, especially within this changing climate.
It is possible that when CNWL becomes a Foundation Trust that we will establish our own forum".

Brent tPCT's PPIF Chair contributed to the final draft of this report as a task group observer. In addition, the joint response to the LINks proposals can be found in Appendix (A).

Summary and Conclusions

> "*Local councils should play a key role in ensuring that involvement frameworks are "fit for purpose" and are able to help "shape the place". Frontline Councillors (through overview and scrutiny or the Community Call for Action) should use their democratic mandate to ensure that decisions made by local councils, the NHS and other partners are influenced by local people*[13]".
>
> **-Centre for Public Scrutiny**

The proposals to create Local Involvement Networks represent both an opportunity and a challenge. There are a lot of unknown factors in the equation at present and the task group itself has been acting within a legislative vacuum. However, we have sought to take a pro-active approach to improving relations between patient forums and scrutiny, as well as other bodies relevant to their work. We hope that closer working will prepare all parties concerned for the changes that are on the horizon from public and patient involvement in health and social care.

The task group wanted to outline the principles that should be upheld, as well as pick out some of the key issues. We hope that some of the practical suggestions we have made in our recommendations will help us to build momentum locally and ensure that those forums concerned will be supported in the transition period in getting the most out of the reformed structures.

LINks have the potential to be a flexible method that will allow for wider and grater participation, their success, however, will be determined by the model contract upon which they are based, forwarded from the Department of Health. Whilst structures and organisations are not an end in themselves, they do determine the framework for development. We are keen to ensure that changes remain outcome focused, ensuring effective representation for public and patients alike.

There has been talk of LINKs being "virtual" networks. We believe that this is unhelpful and that it confuses those who will be necessary in ensuring their success. There is then a need for a greater steer from Government and more guidance as to how we realise these proposals.

The current arrangement for public and patient involvement are not perfect, but we recognise that in reforming them we must ensure that existing good practice, effort, and commitment is retained.

[13] Evidence submitted by The Centre for Public Scrutiny to the House of Commons Health Select Committee

Recommendations

1. **That referrals from local patient forums should be a standing item for each meeting of the Health Select Committee. This should be a time-limited item and subject to the usual agenda management arrangements. This would also allow the committee to make provision to receive annual or quarterly reports from the forums (in the interim) and the LINks, longer term. These would be focused items highlighting both positive and negative aspects, as well as potential topics for scrutiny. Forthcoming referral powers in legislation would formalise this further.**

2. **That the Health Select Committee appoint an observer to the committee to act as a communication channel between Overview & Scrutiny and LINks. This would help provide continuity in the interim and facilitate an improved information exchange.**

3. **That the Health and Social Care Partnership Board is a recognised driver within the PCT that works. Future changes need to preserve its established good practice. The work of the HSCPB should be reviewed in-depth in relation to the LINks legislation. This would allow for a formal and direct reporting line to the LSP, which would allow LINks to make recommendations and referrals.**

4. **That the Executive locally "ring-fence" future resource allocations for LINks development[14]. This would help to remove the ambiguity surrounding the Department of Health's "target budget" approach. In principle, new money should be spent in relation to the specific purpose for which it is allocated.**

5. **That the Health Select Committee considers an effective response to the LINks legislation once the Bill becomes an Act. This may involve reconvening this task group or conducting a focused meeting on the issues raised with the effected parties.**

[14] This recommendation would be put to the Executive once the "*Local Government and Public Involvement in Health Bill*" (Bill 16 06/07) is ratified and LINks become a reality.

This task group received comment from:

- **Oonagh Heron, Chair, North West London Hospitals Trust PPI Forum**
- **Maurice Hoffman, Chair, Central and North West London Mental Health NHS Trust PPIF**
- **Mansukh Raichuria, Chair, Brent teaching Primary Care Trust PPIF**
- **Judith Lockhart, PPIF Manager, Brent teaching Primary Care Trust PPIF**

Appendix (A) Joint Council/tPCT Response to Government Consultation

Appendix (B) O&S Diagram

Appendix (C) "Local Strategic Partnership Structure"

Appendix (D) "Health & Social Care Services in Brent Partnership Arrangements"